WSTA
WESTERN STATES TRUCKING ASSOCIATION

Guardian Dental/Vision Election Form | Plan Year 12/01/2018 – 11/30/2019

Guardian Group# 554633

334 N Euclid Ave, Upland, California 91768

Employee Name:_____ SS# _____

Home Address:_____ City_____ State:_____ Zip Code: _____

Email:_____ Phone: _____

Date of Birth:_____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Domestic Partner

Employer name :_____

Section 1: Dental Election  $1500 Annual Max

Tiers	Guardian PPO Low
Employee Only	☐ $41.58
Employee + One	☐ $82.49
Employee + Two or more	☐ $136.59
Waive	☐

Section 2: Dental Election  $2000 Annual Max

Tiers	Guardian PPO High
Employee Only	☐ $52.66
Employee + One	☐ $104.47
Employee + Two or more	☐ $172.99
Waive	☐

Section 3: Dental Election 

Tiers	Guardian HMO
Employee Only	☐ $11.14
Employee + One	☐ $21.17
Employee + Two or more	☐ $29.52
Waive	☐

Section 4: Vision Election 

Tiers	Guardian (VSP)
Employee Only	☐ $6.90
Employee + Spouse	☐ $13.85
Employee + Child(ren)	☐ $11.72
Employee + Family	☐ $19.33
Waive	☐

Note: The rate shown is the total monthly rate and does not indicate what the employer paid amount is. Please check with employer to find out what amount they pay!

Section 5: Dependent Information

	Dependent Name	DOB	Age	Social Security Number	Gender	Plan Enrolling (please circle)
Spouse						Den Vis
Child						Den Vis
Child						Den Vis
Child						Den Vis

*See next page

WSTA WESTERN STATES TRUCKING ASSOCIATION
334 N Euclid Ave, Upland, California 91768

Section 5: continued Dependent Information

Dependent Name		DOB	Age	Social Security Number	Gender	Plan Enrolling (please circle)
Child						Den Vis
Child						Den Vis
Child						Den Vis
Child						Den Vis

Section 6: Primary Care Physicians (HMO Plans, Kaiser does not require a PCP Selection) If you would like to be Auto Assigned a PCP enter "Auto"

Employee	Guardian Dental PCP #	Guardian Dental PCP Name
Employee		
Spouse		
Child		
Child		
Child		
Child		
Child		

Enrollment Contact

Please contact Liliana Quiroz if you have any questions regarding enrollment or the plan offerings.

Email: lquiroz@bxall.com **Phone Number: (949) 334-8992**

SBC (Summary Benefit Coverages)	Initial Here
I understand the Medical SBC's (Summary of Benefit Coverages) and all ACA required notices can be found on the www.accessourbenefits.com under "SBC & Notices."	**X**

Open Enrollment/Waiting Period Acknowledgement	Initial Here
Open Enrollment I acknowledges that all provisions of my employer's benefits have been explained to me and I have been given the opportunity to participate. I also understand any benefit elections made at this time are effective 12/01/2018 and cannot be changed until 12/01/2019, unless there is a "Qualifying Event" as defined by the insurance carrier. If I waive coverage during this period, I understand I nor any dependents can enroll into any benefits until 12/01/2019, unless there is a "Qualifying Event" as defined by the insurance carrier. **Waiting Period** I acknowledge as a new hire I have a waiting period First of the Month Following Date of Hire in which I can enroll or waive any benefits. I understand any benefit elections made at this time are effective when I meet my "Waiting Period", mentioned above, and cannot be changed until 12/01/2019, unless there is a "Qualifying Event" as defined by the insurance carrier. If I waive coverage during this period, I understand I nor any dependents can enroll into any benefits until 12/01/2019, unless there is a "Qualifying Event" as defined by the insurance carrier.	**X**

Authorization and Certification

I desire to participate in the coverages selected above and hereby authorize my employer to make the necessary deductions from my wages to pay my portion of the premium. I understand that my payroll deduction amount will change if my coverage or cost change.
By signing below I attest that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Signature:_____ **Date:**_____